



**Immediately notify
DOH Communicable
Disease Epidemiology
Phone: 877-539-4344**

Cholera

County _____

LHJ Use ID _____
☐ Reported to DOH Date ____/____/____
LHJ Classification ☐ Confirmed
☐ Probable
By: ☐ Lab ☐ Clinical
☐ Other: _____
Outbreak # (LHJ) _____ (DOH) _____

DOH Use ID _____
Date Received ____/____/____
DOH Classification
☐ Confirmed
☐ Probable
☐ No count; reason: _____

REPORT SOURCE

Initial report date ____/____/____

Reporter (check all that apply)

☐ Lab ☐ Hospital ☐ HCP

☐ Public health agency ☐ Other

OK to talk to case? ☐ Yes ☐ No ☐ Don't know

Investigation
start date:
____/____/____

Reporter name _____

Reporter phone _____

Primary HCP name _____

Primary HCP phone _____

PATIENT INFORMATION

Name (last, first) _____

Address _____ ☐ Homeless

City/State/Zip _____

Phone(s)/Email _____

Alt. contact ☐ Parent/guardian ☐ Spouse ☐ Other Name: _____

Phone: _____

Occupation/grade _____

Employer/worksite _____ School/child care name _____

Birth date ____/____/____ Age _____

Gender ☐ F ☐ M ☐ Other ☐ Unk

Ethnicity ☐ Hispanic or Latino

☐ Not Hispanic or Latino

Race (check all that apply)

☐ Amer Ind/AK Native ☐ Asian

☐ Native HI/other PI ☐ Black/Afr Amer

☐ White ☐ Other

CLINICAL INFORMATION

Onset date: ____/____/____ ☐ Derived

Diagnosis date: ____/____/____

Illness duration: _____ days

Signs and Symptoms

Y N DK NA

☐ ☐ ☐ ☐ **Diarrhea** Maximum # stools in 24 hours: _____

☐ ☐ ☐ ☐ Bloody diarrhea

☐ ☐ ☐ ☐ Watery diarrhea

☐ ☐ ☐ ☐ Abdominal cramps or pain

☐ ☐ ☐ ☐ Nausea

☐ ☐ ☐ ☐ **Vomiting**

☐ ☐ ☐ ☐ **Fever** Highest measured temp (°F): _____

☐ Oral ☐ Rectal ☐ Other: _____ ☐ Unk

☐ ☐ ☐ ☐ Headache

☐ ☐ ☐ ☐ Muscle aches or pain (myalgia)

☐ ☐ ☐ ☐ Rash

Predisposing Conditions

Y N DK NA

☐ ☐ ☐ ☐ Antibiotic use in 30 days prior to onset

☐ ☐ ☐ ☐ Antacid use regularly

☐ ☐ ☐ ☐ H2 blocker or ulcer medication (e.g. Tagamet, Zantac, Omeprazole)

☐ ☐ ☐ ☐ Immunosuppressive therapy or disease

☐ ☐ ☐ ☐ Systemic corticosteroids in last 30 days

☐ ☐ ☐ ☐ Chemotherapy 30 days prior to onset

☐ ☐ ☐ ☐ Cancer, solid tumors, or hematologic malignancies

☐ ☐ ☐ ☐ Radiotherapy in last 30 days

☐ ☐ ☐ ☐ Insulin-dependent diabetes

☐ ☐ ☐ ☐ Chronic diabetes

☐ ☐ ☐ ☐ Gastric surgery or gastrectomy in past

☐ ☐ ☐ ☐ Chronic heart disease

☐ ☐ ☐ ☐ Preexisting heart failure

☐ ☐ ☐ ☐ Chronic kidney disease

☐ ☐ ☐ ☐ Chronic liver disease

☐ ☐ ☐ ☐ Peptic ulcer

☐ ☐ ☐ ☐ Alcoholism

Clinical Findings

Y N DK NA

☐ ☐ ☐ ☐ Hematologic disease

☐ ☐ ☐ ☐ Shock

☐ ☐ ☐ ☐ Other clinical findings consistent with illness

Specify: _____

☐ ☐ ☐ ☐ Admitted to intensive care unit

Hospitalization

Y N DK NA

☐ ☐ ☐ ☐ Hospitalized for this illness

Hospital name _____

Admit date ____/____/____ Discharge date ____/____/____

Y N DK NA

☐ ☐ ☐ ☐ Died from illness Death date ____/____/____

☐ ☐ ☐ ☐ Autopsy Place of death _____

Vaccination History

Y N DK NA

☐ ☐ ☐ ☐ Cholera vaccine in past

Cholera vaccine type _____

Date of last cholera vaccine (mm/yyyy) ____/____/____

Laboratory

P = Positive O = Other, unknown
N = Negative NT = Not Tested
I = Indeterminate

Collection date ____/____/____

P N I O NT

☐ ☐ ☐ ☐ ☐ **Toxigenic cholera culture (stool, vomitus)**

Serotype/Group: _____

Species/Organism: _____

☐ ☐ ☐ ☐ ☐ **Serology for recent toxigenic cholera infection**

INFECTION TIMELINE

Enter onset date (first sx) in heavy box. Count forward and backward to figure probable exposure and contagious periods

Exposure period
Days from onset: -5 -0

o
n
s
e
t

Contagious period

days to (rarely) months

Calendar dates:

EXPOSURE* (Refer to dates above)

Y N DK NA

- ☐ ☐ ☐ ☐ Travel out of the state, out of the country, or outside of usual routine
Out of: ☐ County ☐ State ☐ Country
Destinations: _____
Date left: _____
Date returned: _____

- ☐ ☐ ☐ ☐ Case knows anyone with similar symptoms
☐ ☐ ☐ ☐ Contact with lab confirmed case
☐ ☐ ☐ ☐ Contact with diapered or incontinent child or adult
☐ ☐ ☐ ☐ Shellfish or seafood
County or location shellfish collected: _____

Undercooked, or raw: ☐ Y ☐ N ☐ DK ☐ NA☐ **Section IV of CDC surveillance report form completed (see note below)**

- ☐ ☐ ☐ ☐ Handled raw seafood

☐ Patient could not be interviewed☐ No risk factors or exposures could be identified

Y N DK NA

- ☐ ☐ ☐ ☐ Known contaminated food product
☐ ☐ ☐ ☐ Group meal (e.g. potluck, reception) ☐ ☐ ☐ ☐
Food from restaurants
Restaurant name/location: _____

Y N DK NA

- ☐ ☐ ☐ ☐ Source of drinking water known
☐ Individual well ☐ Shared well
☐ Public water system ☐ Bottled water
☐ Other: _____
☐ ☐ ☐ ☐ Drank untreated/unchlorinated water (e.g. surface, well)
☐ ☐ ☐ ☐ Recreational water exposure (e.g. lakes, rivers, pools, wading pools, fountains)
☐ ☐ ☐ ☐ Sewage or human excreta
☐ ☐ ☐ ☐ Contact with recent foreign arrival (e.g. immigrant, refugee, adoptee, visitor)
Specify country: _____

Most likely exposure/site: _____

Site name/address: _____

Where did exposure probably occur? ☐ In WA (County: _____) ☐ US but not WA ☐ Not in US ☐ Unk

Note: Section IV (only) of the CDC surveillance report form is also required for each seafood type ingested during the exposure period. The CDC surveillance report form can be found at:

<http://www.doh.wa.gov/ehp/sf/vibqx.pdf>

PATIENT PROPHYLAXIS / TREATMENT

Y N DK NA

- ☐ ☐ ☐ ☐ Antibiotics prescribed for this illness Antibiotic name: _____
Date antibiotic treatment began: ____/____/____ # days antibiotic actually taken: _____

PUBLIC HEALTH ISSUES

Y N DK NA

- ☐ ☐ ☐ ☐ Employed as food worker
☐ ☐ ☐ ☐ Non-occupational food handling (e.g. potlucks, receptions) during contagious period
☐ ☐ ☐ ☐ Employed in child care or preschool
☐ ☐ ☐ ☐ Attends child care or preschool
☐ ☐ ☐ ☐ Household member or close contact in sensitive occupation or setting (HCW, child care, food)
☐ ☐ ☐ ☐ Outbreak related

PUBLIC HEALTH ACTIONS

- ☐ Prophylaxis of appropriate contacts recommended
Number recommended prophylaxis: _____
Number receiving prophylaxis: _____
Number completing prophylaxis: _____
☐ Exclude case from sensitive occupations (HCW, food, child care) or situations
☐ Test symptomatic contacts
☐ Notify others sharing exposure
☐ Other, specify: _____

NOTES

Investigator _____ Phone/email: _____ Investigation complete date ____/____/____

Local health jurisdiction _____ Record complete date ____/____/____